Definitions

I. *ACRONYMS AND* DEFINITIONS

These definitions replace the definitions in Section I of the contract. **To be as specific as possible as to the intent of TRICARE Management Activity (TMA), the following *acronyms and* definitions have been included as part of this manual. Many of the *items* are general in nature and some assign meaning to relatively common terms within the health insurance industry; others are applicable only to TRICARE. However, they all appear here solely for the purposes of TRICARE. The *acronyms and* definitions in this chapter apply generally throughout this manual, unless otherwise specified.**

Acronyms

ACOR. *Alternate Contracting Officer's Representative*

ACO. *Administrative Contracting Officer*

ADA. *Americans with Disabilities Act*

ADFM. *Active Duty Family Member*

ADP. *Automated Data Processing*

ADSM. *Active Duty Service Member*

AIS. *Automated Information Systems*

AM&S. *Office of Acquisition Management and Support*

BBP. *Bloodborne Pathogens Program*

BPA. *Bid-price Adjustment*

BRAC. *Base Realignment and Closure*

C&CS. *Office of Communications and Customer Service*

CEIS. *Corporate Executive Information System*

CHCBP. *Continued Health Care Benefits Program*

CHCS. *Composite Health Care System*

CMAC. *CHAMPUS Maximum Allowable Charge*

COB. *Coordination of Benefits*

COR. *Contracting Officers Representative*

CQMP. *Clinical Quality Management Program*

CRM. *Contract Resource Management Directorate*

CF&A. *Contract Finance and Accounting Office*

DCAA. *Defense Contract Audit Agency*

Definitions

DEERS. *Defense Enrollment Eligibility Reporting System*

DMIS. *Defense Medical Information System*

DoD. *Department of Defense*

DRG. *Diagnostic Related Group*

DVA. *Department of Veterans Affairs*

EBC. *Enrollment Based Capitation*

EHP. *Employee Health Program*

EMC. *Electronic Media Claim*

EOB. *Explanation of Benefits*

FAR. *Federal Acquisition Regulations*

FASB. *Federal Accounting Standards Board*

FEHBP. *Federal Employee Health Benefit Program*

FMDP. *Family Member Dental Program*

GSU. *Geographically Separated Units (now known as TRICARE Prime Remote Units)*

HBA. *Health Benefits Advisor*

HCFA. *Health Care Financing Administration*

HCPR. *Health Care Provider Record*

HCSR. *Health Care Service Record*

HEAR. *Health Enrollment Assessment Review*

HEDIS. *Health Plan Employer Data and Information Set*

HHS. *Health and Human Services*

HIPAA. *Health Insurance Portability and Accountability Act of 1996*

HPA&E. *Office of Health Program Analysis and Evaluation*

HMO. *Health Maintenance Organization*

IM/IT. *Information Management/Information Technology*

IMT&R. *Office of Information Management, Technology & Reengineering*

IPT. *Integrated Process Team*

KO. *Contracting Officer*

LA. *Lead Agent*

Definitions

***MA&HP**. Office of Medical Affairs and Health Programs*

***MCS**. Managed Care Support*

***MCSC.** Managed Care Support Contractor*

***MHS**. Military Health System*

***MHSO**. Office of Military Health Systems Operations*

***MHSS**. Military Health Services System (now known as the Military Health System)*

***MTF**. Military Treatment Facility*

***NAS**. Non-Availability Statement*

***NDMS**. National Disaster Medical System*

***NEDB**. National Enrollment Data Base*

***NMOP**. National Mail Order Pharmacy*

***NQMC**. National Quality Monitoring Contractor*

***OASD(HA)**. Office of the Assistant Secretary of Defense (Health Affairs)*

***OHI**. Other Health Insurance*

***OSHA**. Federal Occupational Safety and Health Act*

***PCM**. Primary Care Manager*

***PCO**. Procuring Contracting Officer*

***PERMS**. Provider Education and Relations Management System*

***PFPWD**. Program for Persons with Disabilities*

***POS**. Point of Service*

***PPO**. Preferred Provider Organization*

***QM**. Quality Management*

***RTC**. Residential Treatment Center*

***SHCP**. Supplemental Health Care Program*

***STS**. Specialized Treatment Services*

***TAMP**. Transitional Assistance Management Program*

***TED**. TRICARE Encounter Data*

***TMA**. TRICARE Management Activity*

***TPL**. Third Party Liability*

TPR. *TRICARE Prime Remote*

TSC. *TRICARE Service Center*

UM. *Utilization Management*

WC. *Workers Compensation*

Definitions

These definitions replace the definitions found in Section I of the contract.

Abortion. *The intentional termination of a pregnancy by artificial means done for a purpose other than that of producing a live birth. A spontaneous, missed, or threatened abortion or termination of an ectopic (tubal) pregnancy are not included within the term "abortion" as used herein,*

Absent Treatment. *Services performed by Christian Science practitioners for a person when the person is not physically present.*

NOTE:

Technically, "Absent Treatment" is an obsolete term. The current Christian Science terminology is "treatment through prayer and spiritual means," which is employed by an authorized Christian Science practitioner either with the beneficiary being present or absent. However, to be considered for coverage under TRICARE, the beneficiary must be present physically when a Christian Science service is rendered, regardless of the terminology used.

Abuse. *For the purposes of TRICARE, abuse is defined as any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary cost, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care, as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim.*

NOTE:

Unless a specific action is deemed gross and flagrant, a pattern of inappropriate practice will normally be required to find that abuse has occurred. Also, any practice or action that constitutes fraud, as defined by this Regulation, would also be abuse

Access, Health Care. *The ability to receive necessary health care services of high quality within the timeframes, at the locations and from the providers that satisfy patient needs and desires.*

Access, Information.

1. The availability of or the permission to consult records, archives, or manuscripts.

2. The ability and opportunity to obtain sensitive, classified, or administratively controlled information or records.

Accidental Injury. *Physical bodily injury resulting from an external force, blow or fall, or the ingestion of a foreign body or harmful substance, requiring immediate medical treatment. Accidental injury also includes animal and insect bites and sunstrokes. For the purpose of TRICARE, the breaking of a tooth or teeth does not constitute a physical bodily injury.*

Action Plan. A contractor's plan for achieving a goal through the use of specific resources based on a time-oriented schedule of activities.

Active Duty. *Full-time duty in the Uniformed Services of the United States. It includes duty on the active list, full-time training duty, annual training duty, and attendance while in the active Military Service, at a school designated as a Service school by law or by the Secretary of the Military Department concerned.*

Active Duty Claims Program. A program established to price certain active duty claims according to TRICARE rules of reimbursement.

Active Duty Member. *A person on active duty in a Uniformed Service under a call or order that does not specify a period of 30 days or less.*

Actual Health Care Service Costs. *(In the application of the risk sharing corridors) The sum of incurred contractor non-capitated costs recorded on HCSRs adjusted to completion using CHAMPUS national completion rates and corrected based upon the results of the adjudication audit, plus audited capitated costs and audited Category 8 costs. If the audit of Category 12 costs has not been accomplished at the time of the first risk sharing adjustment for a given option period, the results of the audits shall be incorporated in the second and final risk sharing adjustment for the option period.*

1. *A net error rate percentage shall be determined from the adjudication audit of a sample of non-capitated HCSRS, as described in Section F of the contract. The actual net payment error rate for institutional HCSRs and for non-institutional HCSRs shall be the amount of overpayment (positive amount) or underpayment (negative amount) divided by total payments for institutional HCSRs and non-institutional HCSRs.*

2. *In the case of a net overpayment, the total non-capitated HCSR claims dollars (adjusted to completion) shall be multiplied by 1 - net payment error rate, and the result shall be used to represent actual costs for categories of care 1 through 7. For example, if the audit determines that the audited HCSR sample reflects a two percent overpayment, total non-capitated HCSR claims dollars adjusted to completion shall be multiplied by 98, and the result shall be added to audited capitated costs and audited Category 8 costs to reflect actual health care costs for the purposes of risk sharing.*

3. *In the case the HCSR adjudication audit identifying net underpayments, the total HCSR claims dollars (adjusted to completion) shall reflect any actual additional payments made by the contractor as a result of the audit. The contractor must submit the additional HCSRs resulting from the reconciliation payments made in these instances.*

Acupuncture. *The practice of inserting needles into various body parts to pierce specific peripheral nerves for the production of counter-irritation to relieve the discomfort of pain, induce surgical anesthesia, or for other treatment purposes.*

NOTE:

Acupuncture is not covered by TRICARE.

Adequate Medical Documentation, Medical Treatment Records. *Adequate medical documentation contains sufficient information to justify the diagnosis, the treatment plan, and the services and supplies furnished. Under TRICARE, it is required that adequate and sufficient clinical records be kept by the health care provider(s) to substantiate that specific care was actually and appropriately furnished, was medically necessary and appropriate (as defined by 32 CFR Part 199), and to identify the individual(s) who provided the care. All procedures billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under generally acceptable standards such as the applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, the Peer Review Organization (PRO) standards (and the provider's state or local licensing requirements) and other requirements specified by this Regulation. In general, the documentation requirements for a professional provider are not less in the outpatient setting than the inpatient setting.*

Adequate Medical Documentation, Mental Health Records. *Adequate medical documentation provides the means for measuring the type, frequency, and duration of active treatment mechanisms employed and progress under the treatment plan. Under TRICARE, it is required that adequate and sufficient clinical records be kept by the provider to substantiate that specific care was actually and appropriately furnished, was medically or psychologically necessary (as defined by 32 CFR Part 199), and to identify the individual(s) who provided the care. Each service provided or billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under generally acceptable standards (e.g., the applicable JCAHO standards and the provider's state or local licensing requirements) and other requirements specified by this Regulation. It must be noted that the psychiatric and psychological evaluations, physician orders, the treatment plan, integrated progress notes (and physician progress notes if separate from the integrated progress notes), and the discharge summary are the more critical elements of the mental health record. However, nursing and staff notes, no matter how complete, are not a substitute for the documentation of services by the individual professional provider who furnished treatment to the beneficiary. In general, the documentation requirements of a professional provider are not less in the outpatient setting than the inpatient setting. Furthermore, even though a hospital that provides psychiatric care may be accredited under the JCAHO manual for hospitals rather than the consolidated standards manual, the critical elements of the mental health record listed above are required for TRICARE claims.*

Adjunctive Dental Care. *Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or, is required in preparation for or as the result of dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).*

Definitions

Adjustment. A correction to the information in the *TRICARE encounter data (TED)* and/or Beneficiary History Files (Hard Copy Files and Automated Beneficiary History and Deductible Files) related to a claim previously processed to completion by the current contractor. Adjustments include any recoupments, additional payment(s), all cancellations (total or partial), and corrections to statistical data, whether or not the changes result in changes to the financial data.

Adjustment, Identification of (Receipt). An adjustment may be generated by a telephonic, written or personal inquiry, appeal decision, or as the result of a contractor's internal review. The adjustment is identified when the contractor's staff determines the issue requires an additional payment, cancellation, or a change to the Beneficiary History and Deductible Files (see definition) or when notice is received from TMA that an adjustment is required. In the case of recoupments, the adjustment is "identified" for reporting purposes, with receipt of the payment into the contractor's custody.

Admission. *The formal acceptance by a TRICARE authorized institutional provider of a TRICARE beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.*

Adopted Child. *A child taken into one's own family by legal process and treated as one's own child. In case of adoption, TRICARE eligibility begins as of 12:01 am. of the day of the final adoption decree. NOTE: There is no TRICARE benefit entitlement during any interim waiting period.*

All-Inclusive Per Diem Rate. *The TMA-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient.*

Allowable Charge. The TRICARE-determined level of payment to physicians and other categories of individual professional providers based on one of the approved reimbursement methods set forth in the OPM Part Two, Chapter 4. As used by TRICARE, the allowable charge shall be the lowest of the billed charge, the prevailing charge, or the maximum allowable prevailing charge. *For network/contracted providers, the allowable charge shall be the contracted amount.*

NOTE:

Under a program approved by the Director, TMA, where a non-network provider has agreed to discount his or her charges, the discounted charge shall be used in place of the billed charge in allowable charge calculations unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used in the allowable charge calculations.

Allowable Charge Complaint. A request for review of a contractor determination of allowable charge for covered services and supplies furnished under TRICARE. The allowable charge complaint does not fall within the meaning of an "appeal", in the technical sense, but does require a careful contractor review of the claim processing to ensure accuracy of the allowance made.

Allowable Charge Reduction. The difference between the reimbursement determination made by a contractor and the amount billed by the provider of care (prior to determination of applicable cost-shares and deductibles).

Allowable Cost. The *TRICARE*-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods *described in 32 CFR 199.14. Allowable cost may also be referred to as the TRICARE-determined reasonable cost.*

Ambulance. *A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.*

Ambulatory Surgery. *Surgery provided to the patient on an outpatient, walk-in, same day basis in an appropriately equipped and staffed health facility with surgery usually conducted under general anesthesia with no overnight stay in the hospital required. Also called same day surgery.*

Amount in Dispute. *The amount of money, determined under 32 CFR 199, that TRICARE would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See 32 CFR 199.10 for additional information concerning the determination of "amount in dispute" under the Regulation.*

Anesthesia Services. *The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.*

Appeal. A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See the *32 CFR 199* and the Operations Manual 6010.49-M.

Appealable Issue. Disputed question of fact which, if resolved in favor of the appealing party, would result in the authorization of TRICARE benefits, or approval as an authorized provider in accordance with the *32 CFR 199*. There is no appealable issue if no facts are in dispute, if no TRICARE benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. *32 CFR 199.10* provides additional information concerning the determination of "appealable issue."

Appealing Party. *Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of 32 CFR 199.*

Appropriate Medical Care.

1. *Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;*

2. *The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets TRICARE standards; and*

3. *The services are furnished economically. "Economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE.*

Approved Teaching Programs. *For purposes of TRICARE, an approved teaching program is a program of graduate medical education which has been duly approved in its respective specialty or subspecialty by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatry Education of the American Podiatry Association.*

Assistant Secretary of Defense (Health Affairs). *An authority of the Assistant Secretary of Defense (Health Affairs) includes any person designated by the Assistant Secretary to exercise the authority involved.*

Attending Physician. *The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant or an assistant surgeon, for example, would not be an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time. An attending physician also may be a teaching physician.*

Authorization for Care*. The determination that the requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by DoD through its MCS contract. (All NAS issuances need to be prior authorized.)*

Authorized Provider. *A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under 32 CFR 199.*

Automated Data Processing (ADP). A system for recording and processing data on magnetic media, ADP cards, or any other method for mechanical/electronic processing and manipulation or storage of data.

Automated Data Processing and Reporting Manual (6010.50). A TMA manual which provides ADP instructions and requirements for contractors who use the Health Care Service Records (HCSRs) system for reporting data to TMA.

Backup Hospital. *A hospital that is otherwise eligible as a TRICARE institutional provider and that is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of TRICARE-authorized freestanding institutional provider and which is accessible from the site of the TRICARE-authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.*

Backup System. A separate, off-site automated data processing system with similar operating capabilities which will be activated/used in case of a major system failure,

damage, or destruction. This includes back-up data sets, software and hardware requirements, and trained personnel.

Balance Billing. *The practice of a provider billing a beneficiary the difference between the TRICARE allowed amount and the billed charges on a claim. Participating providers and network providers may not collect from all sources an amount which exceeds the TRICARE allowed amount. Non-participating providers may not collect an amount which exceeds the balance billing limit (115% of the allowed charge). If the billed charge is less than the balance billing limit, then the billed charge is the maximum amount that can be collected by the non-participating provider*.

Benchmark. A TRICARE clerical and automated systems test using claims and other documents created or approved by TMA and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by TMA to determine the accuracy, completeness and operational characteristics of the contractor's clerical and automated systems components. The purpose of the benchmark is to identify clerical and automated systems deficiencies which must be corrected before claims can be processed in accordance with TMA requirements. The comprehensiveness of the benchmark will vary depending on the number and type of conditions tested.

Beneficiary History File. A system of records consisting of any record or subsystem of records, whether hard copy, microform or automated, which reflects diagnosis, treatment, medical condition, or any other personal information with respect to any individual, including all such records acquired or utilized by the contractor in delivery of health care services, in the development and processing of claims, or in performing any other functions under this contract.

1. Hard Copy Claim and Microform Files

These files may include but are not limited to:

a. Claim forms (TRICARE or other claim form approved by TMA)

b. DD Form 1251, Nonavailability Statement

c. Reports and related documentation pertaining to professional review of treatment

d. Powers of Attorney

e. Other Statements of Legal Guardianship

f. Receipts (Itemized Bills)

g. Other Insurance Payment Information (or EOB)

h. Medical Reports (Mental illness case files, DME, Medical Necessity Statement, Emergency Admission Statement, progress reports, nursing notes, operative reports, test results, etc.).

i. Deductible Certificate (if claimant indicates that deductible has been satisfied or partially satisfied via claims processed by a different contractor).

j. Timely Filing Waiver

k. Claim-Related Correspondence

l. Appeals Case File

m. Any other contractor developed documentation which is used for recording and documenting care and payment for care by network providers of care.

2. ***Automated History Files***. The electronically maintained record of a beneficiary's medical care and related administrative data, including such data on charges, payments, deductible status, services received, diagnoses, adjustments, etc. (See OPM Part Two, Chapter 1 and Chapter 3.)

Capitated Claims/Encounters/Resource Sharing Services. *Claims, encounters, or resource sharing services that are paid (usually monthly) based on a predetermined fee per individual/family assigned to a network provider. Payments are not determined by the number of services or types of procedures rendered.*

Catchment Areas. Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of 5-digit zip codes, usually within an approximate 40-mile radius of military inpatient treatment facilities. Beneficiaries not enrolled in TRICARE Prime residing in these areas are required to receive all inpatient care from the military treatment facility or obtain a Nonavailability Statement (NAS) (see definition) that authorizes civilian inpatient care for a particular inpatient service.

Certification for Care. *The determination that the provider's request for care (level of care, procedure, etc.) is consistent with preestablished criteria. (Note: This is NOT synonymous with authorization for care).*

CHAMPUS Maximum Allowable Charge (CMAC). *CMAC is a nationally determined allowable charge level that is adjusted by locality indicies and is equal to or greater than the Medicare Fee Scheduled amount.*

Change Order. A written directive from the TMA Contracting Officer to the contractor directing changes within the general scope of the contract, as authorized by the "changes clause."

Claim. Any request for payment for services rendered related to care and treatment of a disease or injury which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or approved electronic media. If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the

contractor from collecting the data necessary to fulfill the requirements of the health care service record for all care provided under the contract.)

Claim File. The collected records submitted with or developed in the course of processing a single claim. It includes the approved TRICARE claim form and may include attached bills, medical records, record of telephone development, copies of correspondence sent and received in connection with the claim, the EOB, and record of adjustments to the claim. It may also include the record of appeals and appeal actions. The claim file may be in microcopy, hard copy, or in a combination of media, as approved by TMA.

Claim Form. A fixed arrangement of captioned spaces designed for entering and extracting prescribed information, including ADP system forms.

Claim Forms, Authorized.

1. ***UB-92, HCFA-1450***

   The national standard claim form (except for New York where the UB-F-1 is authorized for TRICARE) used by institutional providers for submission of claims for inpatient and outpatient institutional services. The UB-92 may be used by institutional providers and Home Health Care Agencies to bill for professional services. The UB-92 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology to include any negotiated rates. Contractors shall contact any Home Health Care Agency that has requested to bill for professional services on the UB-92 to assist them with the proper billing requirements, e.g., CPT procedure codes, name of the actual provider, etc.

2. ***Form HCFA-1500***

   A claim form used for the submission of claims for noninstitutional services by physicians and all other individual providers of care. This form is accepted from beneficiaries although it is not designed for beneficiary use.

3. ***DD Form 2520***

   A form used for submitting a claim requesting payment for inpatient or outpatient medical services or supplies when provided by civilian sources of medical care. This form is authorized for use only outside the United States. Beneficiaries or providers may use this form. Beneficiaries complete this form and attach bills and/or receipts for any service where a provider will not complete a claim form for him/her.

Claims Cycle Time. That period of time, recorded in calendar days, from the receipt of a claim into the possession/custody of the contractor to the completion of all processing steps including, when required, printing of the check and EOB.

Clean Claim. *A claim received by the contractor that has no defect, impropriety or particular circumstance requiring special treatment preventing timely payment. If a claim can be perfected using in-house information, it is considered "clean."*

Coinsurance. See the definition for "cost-share."

Community Health Accreditation Program (CHAP). *An evaluating body for home and community health care organizations. CHAP is an independent subsidiary of the National League for Nursing.*

Concurrent Review/Continued Stay Review. *Evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of care (including outpatient care).*

Confidentiality Requirements. The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, and the Privacy Act.

Continued Health Care Benefit Program. The Continued Health Care Benefit Program (CHCBP) was established by the National Defense Authorization Act for FY 1993, and provides temporary continued TRICARE benefits for certain former TRICARE beneficiaries. Coverage under the CHCBP is purchased on a premium basis. See OPM Part Two, Chapter 16 for additional information.

Contract Performance Evaluation. The review by TMA, of a contractor's level of compliance with the terms and conditions of its contract. Usually, an operational audit performed by TMA staff focuses on timeliness, accuracy, and responsiveness of the contractor in performing all aspects of the work required by the contract.

Contract Physician. A physician who has made contractual arrangements with a contractor to provide care or services to TRICARE beneficiaries. A contract physician is a network provider who participates on all TRICARE claims.

Contracting Officer. *A Government employee having authority vested by a Contracting Officer's Warrant to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate Government funds and commit the Government to contractual terms and conditions.*

Contractor. An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

Control of Claims. The ability to identify individually, locate, and count all claims in the custody of the contractor by location, including those that may be being developed by physical return of a copy of the claim, and age including total age in-house and age in a specific location.

Controlled Development. The retention of a claim by the contractor in pending inventory, during the time the claim is being completed by investigation, telephone contact, or written contact or return of a copy for information needed to enable the accurate processing and adjudication of the claim.

Coordination of Benefits. A system to require collection of other health insurance benefits before making any TRICARE benefit payment, except for Medicaid, in compliance with requirements specified in the *32 CFR 199* and the Operations Manual.

Copayment. *See the definition for "cost-share."*

Copy. A reproduction of the contents of an original document, prepared simultaneously or separately, usually identified by function or by method of creation. Copies identified by function may include action copy, comeback copy, file or record copy, information or reference copy, official copy, and tickler copy. Copies identified by method of creation include carbon copy, mimeograph copy, ribbon copy, microcopy, and electrostatic copy.

Correspondence. Written requests for information, claims status, benefit coverage, and other inquiries of a general nature. A single inquiry may contain a request for the status of several different claims. In this case, a single inquiry shall be counted as one piece of correspondence even though there may be multiple claims attached to the one inquiry. This does not include grievances or appeals.

Cost Effective Provider Network Areas. Areas in which provider networks can be developed where the discounts received from providers and the effects of Utilization Management activities are greater than or equal to the administrative costs associated with maintaining the Provider Network and accomplishing all additional marketing, education, enrollment, and related administrative activities.

Cost-Share. The amount a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, *the balance billing amount,* or disallowed amounts) as set forth in the Regulation, Chapters 4, 5, and 17 (*32 CFR 199.4, 199.5*, and *199.17*). Under TRICARE, cost-shares are expressed in one of two ways:

1. ***Coinsurance***.

   The beneficiary's cost-share expressed as a percentage of allowed charges.

Examples:

(1) *TRICARE Standard: Family members of active duty sponsors pay 20% of the allowed charges for outpatient services. All other beneficiaries (retirees, family members of retirees, survivors, etcetera) pay 25% of the allowed charges for both inpatient and outpatient services (Policy Manual, Chapter 12, Section 2.1 and Policy Manual, Chapter 13, Section 11.1).*

(2) *TRICARE Extra: Family members of active duty sponsors usually pay 15% of the allowed charges for outpatient services. All other beneficiaries (retirees, family members of retirees, survivors, etcetera) usually pay 20% of the allowed charges for both inpatient and outpatient services (Policy Manual, Chapter 12, Section 2.1).*

(3) *TRICARE Prime Point of Service (POS): All TRICARE Prime enrollees who receive care under the POS option pay 50% of the allowed charges for inpatient care and, after meeting the outpatient deductible ($300 for an individual, $600 for a family), 50% of the allowed charges for outpatient care (Policy Manual, Chapter 12, Section 10.1).*

2. ***Copayment***.

   The beneficiary's cost-share expressed as a predetermined, fixed amount.

Examples:

(1) *TRICARE Standard: For each inpatient admission, active duty family members pay the first $25 of allowed institutional charges or a per diem rate for the total number of inpatient days—whichever is greater (Policy Manual, Chapter 13, Section 11.1).*

(2) *TRICARE Prime: For each covered visit or service, enrolled members pay a specific dollar amount which is usually collected at the time of the visit or service (Policy Manual, Chapter 12, Section 2.1).*

(3) *Program for Persons with Disabilities (PFPWD): The beneficiary (or responsible person) pays a fixed amount each month during which the active duty family member receives services under PFPWD. The copayment schedule is based on the sponsor's rank (Policy Manual, Chapter 13, Section 11.6).*

See the 32 CFR 199.4 and 199.17, for beneficiary liability requirements under TRICARE Standard, 32 CFR 199.17 for TRICARE Extra and Prime liability requirements, and Chapter 5 for Program for Persons with Disabilities liability requirements.

Covered Charges. Billed charges for services, supplies, and equipment *furnished by an authorized provider that have been* determined to be benefits of the program and *that have been* properly submitted to a contractor on or attached to, an approved TRICARE claim form.

CPT. The acronym for Current Procedural Terminology published by the American Medical Association. CPT is the required TRICARE procedural coding system for medical procedures for all contracts becoming effective on and after October 1, 1981.

Custody. The guardianship of documents/claims or funds which includes both physical possession (protective responsibility) and legal title (legal responsibility).

CVAC. "CVAC" means the CHAMPVA Center. It is the component within the Department of Veterans Affairs, Health Administration Center (HAC) which processes all CHAMPVA claims.

Cycle Time. The elapsed time, as expressed in calendar days (including any part of the first and last days counted as two days), from the date a claim, piece of correspondence, grievance, or appeal case was received by a contractor through the date processed to completion. (See claims cycle time for added detail.)

Date of Determination (Appeals). "Date of Determination" on an appeal, is the day the final letter on a decision is completed and a previous decision is either reaffirmed, reversed, or partially reversed.

Days. Calendar days unless otherwise indicated.

Deductible. The statutory requirement for payment by the beneficiary of an initial specified dollar amount of the TRICARE-determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year.

Example:

(1) *Under TRICARE Standard and TRICARE Extra, the deductible is $50 (for family members of sponsors in pay grade E-4 and below) or $150.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) For a family, the aggregate payment of $100 (for family members of sponsors in pay grade E-4 and below) or $300.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) by two or more beneficiaries will satisfy the deductible requirement.*

(2) *For TRICARE Prime enrollees, under the Point-of-Service option, the deductible is $300 for individuals, $600 for a family.*

DEERS/TRICARE/Claims Development System. A realtime data system which will provide some sponsor/beneficiary identification information that can assist in claims development. Data available include sponsor's paygrade, sponsor's branch of service, status of sponsor, patient's name, patient's date of birth, patient's sex*, and patient's Prime enrollment status*.

Defense Enrollment Eligibility Reporting System (DEERS). The computer-based enrollment/eligibility system for verifying entitlement to health care services. See the 32 CFR 199 definition and the Automated Data Processing and Reporting Manual (6010.50-M), for specific information concerning DEERS.

Deficiency. (For the purpose of evaluating past performance) a certain level of the offeror's performance under a contract, either with a government agency or commercial business, that fails to satisfy a contract requirement. (Also see FAR 15.306).

Demonstration. A study or test project with respect to alternative methods of payment for health and medical services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the program.

Denial of Authorization. The determination that the proposed treatment or already-provided treatment will not be reimbursed by DoD.

Desk Instructions. Detailed procedures and action requirements which are peculiar to a specific work station or set of work stations which perform the same function. They should be so designed and so adequately detailed that a reasonably qualified person could follow the procedures and accomplish the work at the station without detailed training.

Development of a Claim (Controlled). Controlled development of a claim occurs when an originally submitted claim (and all attached documents) is suspended under control by a contractor during the time that efforts are initiated to acquire missing information. Information can be obtained from sources such as DEERS, the Contractor's Beneficiary History and Deductible File, the beneficiary, or provider.

Diagnosis Related Groups (DRGs). A categorization of hospital patients into clinically coherent groups based on their consumption of resources. Patients are assigned to the

groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status. A reimbursement system using DRGs assigns payment levels to each DRG based on the average cost of treating all patients in a given DRG.

DSM III. A technical reference, Diagnostic and Statistical Manual of Mental Disorders, Third Edition.

DSM IV. A technical reference, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

Edit Error (HCSRs Only). Errors found on HCSRs (initial submissions, resubmissions, and adjustments/cancellation submissions) which result in nonacceptance of the records by TMA. These require correction of the error by the contractor and resubmission of the corrected HCSR to TMA for acceptance.

Emergency Services. Medical services provided for a sudden and unexpected onset of a medical or psychiatric condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. See the Policy Manual for further clarification of emergency services.

Enrollment Plan. A plan established by the Contractor to inform beneficiaries of the availability of the TRICARE Prime enrollment program, facilitate enrollment in the program, and maintain enrollment records. The plan must be approved by the government.

Enrollment Transfer. A transfer of TRICARE Prime enrollment from one location or contractor to another:

1. ***Out-of-Contract Enrollment Transfer.***

   An enrollment transfer requiring information exchange between contractors or, for a managed care area administered by a Lead Agent (e.g., overseas, Alaska, etc.), between a contractor and a Lead Agent. The term "contractors" includes designated providers under the Uniformed Services Family Health Plan (USFHP). See OPM Part Three, Chapter 4, Section II.G.

2. ***Within-Contract Enrollment Transfer.***

   An enrollment transfer within a Managed Care Area which involves a change of address and possibly a change of Primary Care Managers but does not require information exchange between contractors (e.g., an enrollee transfers from Los Angeles, CA, to San Francisco, CA; from Memphis, TN, to Tallahassee, FL; from Denver, CO, to Phoenix, AZ; from Austin, TX, to Abilene, TX; etc.).

Exclusive Provider Organization (EPO). The set of contract providers from whom, as a rule, TRICARE Prime enrollees must receive services to receive TRICARE Prime benefits and have services cost-shared by the Contractor. Members of the EPO may also be PPO members for non-Prime TRICARE beneficiaries.

Explanation of Benefits (EOB). The document prepared by insurance carriers, health care organizations, and TRICARE to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

Federal Records Center (FRCs). Centers established and maintained by the General Services Administration at locations throughout the United States for the storage, processing, and servicing of noncurrent records for Federal agencies.

File.

1. An accumulation of records maintained in a predetermined physical arrangement. Used primarily in reference to current records, the term in archival usage may refer to either a series or a file unit, such as a folder or dossier.
2. To place documents in a predetermined location according to an overall plan of classification.
3. In machine-readable records/archives, two or more data records of identical layout treated as a unit. The unit is larger than a data record but smaller than a data system and is sometimes known as a data set.
4. Storage equipment, such as a filing cabinet.

File Break. The termination of a file at regular periodic intervals to facilitate continuous disposal or transfer of the file series.

Files. A term usually applied collectively to all records.

Files Administration. The application of records management techniques to filing practices to maintain records easily and to retrieve them rapidly, to ensure their completeness, and to facilitate the disposition of noncurrent records.

Fiscal Year. The Federal Government's twelve-month accounting period which currently runs from October 1 through September 30 of the following year.

Fragmented Billing. (See "Unbundled Billing")

Freedom of Choice. The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the direct care system (military treatment facility system), or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard Program (see definition). Beneficiaries who voluntarily enroll in TRICARE Prime must be informed of any restrictions on freedom of choice that may be applicable to enrollees as a result of enrollment. Except for any limitations on freedom of choice that are fully disclosed to the beneficiaries at the time of enrollment, freedom of choice provisions applicable to the TRICARE Standard Program shall be applicable to TRICARE Prime.

Freedom of Information Act. A law enacted in l967 as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

Geographic Adjustment Factor (GAF). Adjustment(s) to the national standardized Medicare Fee Schedule relative value components required by law (OBRA 1989) to account for differences in the cost of practicing medicine in different geographic areas of the country. The GAF is based on the GPCI - the Geographic Practice Cost Index.

Geographic Practice Cost Index (GPCI). An index developed to measure the differences in resource costs among fee schedule areas compared to the national average in the three components of the relative value units - physician work, practice expenses excluding malpractice and, malpractice.

Grievance. A written complaint on a non-appealable issue which deals primarily with a perceived failure of an in-system provider, the health care finder, or Contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

Grievance Process. A Contractor developed and managed system for resolving beneficiary grievances.

Health Care Finder. The person who manages and performs the duties necessary to operate the Health Care Finder System.

Health Care Finder System. A system or mechanism established by the contractor in each catchment area in the region to facilitate referrals of beneficiaries to military and/or civilian health care services.

Health Care Service Record. A data set of information required for all care received/delivered under the contract and provided by the contractor in a government-specified format and submitted to TMA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification (including service affiliation)
2. Provider identification (including type/specialty)
3. Health information:
   - a. Place and type of service
   - b. Diagnosis and treatment-related data
   - c. Units of service (admissions, days, visits, etc.)
4. Related financial information

Health Care Service Record Transmittal Summary. A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of health care records.

Health Care Services Cost. Those amounts paid, or to be paid, by the contractor to individual or institutional providers of authorized health care to TRICARE-eligible beneficiaries, including payments to hospitals for capital and direct medical education, to resource sharing health care providers, and to others for resource sharing equipment.

Hospital Day. An overnight stay at a hospital. Normally if the patient is discharged in less than 24 hours it would not be considered an inpatient stay; however, if the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight, regardless of the actual length of stay, the stay will be considered an inpatient stay and, therefore, a hospital day. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

ICD-9-CM. A technical reference, **International Classification of Diseases, 9th Edition, Clinical Modification**. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care and claims processing contracts becoming effective on and after October 1, 1981.

Individual Consideration (IC) Procedure. An individual consideration procedure is one that is not routinely provided, is unusual, variable, or new. These procedures will require additional information from the provider of care, including an adequate definition or description of the nature, extent and need for the procedure; and the time, effort, and necessary equipment required. Any complexities related to the service should also be identified.

Individual Pricing Summary (IPS). A document that a contractor provides to the originating MTF/Claims Office which indicates the contractor's actions in pricing active duty claims.

Initial Payment. The first payment on a continuing claim, such as a long-term institutional claim.

Inpatient Care. Care provided to a patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Inquiry. Requests for information or assistance made by or on behalf of a beneficiary, provider, the public, or the Government. Written inquiries may be made in any format (letter, memorandum, note attached to a claim, etc.). Allowable charge complaints, grievances, and appeals are excluded from this definition.

In-System Care. See "Network Care."

Internal Control Number (ICN). The unique number assigned to a claim by the contractor to distinguish it in processing, payment, and filing procedures. It is the number affixed to the face of each claim received and will, at a minimum, include the Julian date of receipt and a five-digit sequence number assigned by the contractor. Each health care service record must have a unique internal control number. For records generated from claims, it will be the internal control number of the claim from which it was generated. For health care service records which are not generated from claims, it will be a unique number assigned by the contractor which will include the Julian date of the record's creation and a five-digit sequence number.

Lead Agent. The uniformed services "individual" responsible for supporting TRICARE contract administration in a specific region.

Lead Agent Office. The responsible organizational entity and designated focal point for Tri-Services health services development and planning for a single, integrated healthcare network within an identified Health Service Region (HSR).

License. A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare independently within the scope of practice for a discipline.

1. Current. Active--not revoked, suspended, or lapsed in registration.
2. Valid. The issuing authority accepts, investigates and acts upon quality assurance information such as provider professional performance, conduct, ethics of practice, regardless of the practitioner's status or residency.
3. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants of similar specialty in the granting jurisdiction.

Line Item.

1. Each distinct occurrence, with the attendant charge, separately identified on a claim.
2. With respect to Health Care Service Records, up to fifty (50) occurrences submitted on the same record.

NOTE:

For purposes of (2), contractors have the option of restricting "line item" occurrences to those received in a single month. Also, for mental health services, each separate occurrence may be listed as a line item.

MTF-Referred Care. *When Medical Treatment Facility (MTF) patients require medical care that is not available at the MTF, the MTF will refer the patient to civilian medical care, and the contractor shall process the claim ensuring that discounts, cost-shares, copayments and/or deductibles are applied when appropriate.*

Machine-Readable Records/Archives. The records and archives whose informational content is usually in code and has been recorded on media, such as magnetic disks, drums, tapes, punched paper cards, or punched paper tapes, accompanied by finding aids known as software documentation. The coded information is retrievable only by machine.

Maximum Allowable Prevailing Charge. The TRICARE state prevailing charges adjusted by the Medicare Economic Index according to the methodology as set forth in the OPM Part Two, Chapter 4.

Medical Claims History File. (Refer to Beneficiary History File.)

Medicare Economic Index (MEI). An index used in the Medicare program to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expenses factors including malpractice, personnel costs, rent, and other expenses.

Member Pharmacy. A pharmacy that is a member of the contractor's or a subcontractor's provider network.

MHS Beneficiary. Any individual who is eligible to receive treatment in a Military Treatment Facility. The categories of Military Health System (MHS) beneficiaries shall be

broadly interpreted unless otherwise specifically restricted. (For example: Authorized parents and parents-in-law are not eligible for TRICARE but may access the TRICARE Health Care Information Line (HCIL)).

Microcopy. A photographic reproduction so much smaller than the object photographed that optical aid is necessary to read or view the image. The usual range of reduction is from 8 to 25 diameters. Also called microphotography.

Microfiche. Miniaturized images arranged in rows that form a grid pattern on card-size transparent sheet film.

Microfilm. A negative or a positive microphotograph on film. The term is usually applied to a sheet of film or to a long strip or roll of film that is 16mm, 35mm, 70mm, or 105mm in width and on which there is a series of microphotographs.

Microform. Any miniaturized form containing microimages, such a microcards, microfiche, microfilm, and aperture cards.

Military Medical Support Office (MMSO). *The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty. MMSO is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. The Service Points of Contact (SPOCs) for Army, Navy, Marine Corps, and Air Force active duty service members (ADSMs) are assigned to the MMSO. See also Service Point of Contact definition.*

Military Treatment Facility/Claims Office. The Service office that will forward active duty claims to a contractor for pricing.

Military Treatment Facility (MTF). A military hospital or clinic.

Mobilization Plan - TRICARE. A plan designed to ensure the government's ability to meet the medical care needs of the TRICARE-eligible beneficiaries in the event of a military mobilization that precludes use of all or parts of the military direct care system for provision of care to TRICARE-eligible beneficiaries.

Monthly Pro-Rating. The process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for ten (10) months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

National Appropriate Charge Level. The charge level established from a 1991 national appropriate charge file developed from July 1986 - June 1987 claims data, by applying appropriate Medicare Economic Index (MEI) updates through 1990, and prevailing charge cuts, freeze or MEI updates for 1991 as discussed in the September 6, 1991, final rule.

National Conversion Factor (NCF). A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

National Disaster Medical System (NDMS). A system designed to ensure that the United States is prepared to respond medically to all types of mass casualty emergency situations, whether from a natural or man-made disaster in the country or from United States military casualties being returned from an overseas conventional conflict. This system involves private sector hospitals located throughout the United States that will provide care for victims of any incident that exceeds the medical care capability of any affected state, region, or federal medical care system.

National Prevailing Charge Level. The level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during a 12-month base period.

National Quality Monitoring Contract. A national-level contractor responsible to DoD and TRICARE Management Activity (TMA) that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

Negotiated (Discounted) Rate. The negotiated or discounted rate, under a program approved by the Director, TMA, is the reimbursable amount that the provider agrees to accept in lieu of the usual TRICARE reimbursement, the DRG amount, the mental health per diem, or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

Network. The network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. The agreements for health care delivery made by the contractor with the MTFs are also included in this definition.

Network Care. Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a “network provider” is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor. “Network care” includes any care provided by a “network provider” or any care provided to a TRICARE Prime enrollee under a referral from the contractor, whether by a “network provider” or not. A “network claim” is a claim submitted for “network care.” (See the definition for “Non-Network Care.”)

Network Provider. An individual or institutional provider that is a member of a contractor’s provider network.

NOAA. The Commissioned Corps of the National Oceanic and Atmospheric Administration.

Nonappealable Issue. The issue or basis upon which a denial of benefits was made based on a fact or condition outside the scope of responsibility of TMA and the contractor. For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither TMA nor a contractor may review the action. Similarly, the need for a Nonavailability Statement, late claim filing, late appeal filing, amount of allowable charge (the contractor must verify it was properly applied and calculated), and services or supplies specifically excluded by law or regulation, such as routine dental care, clothing, routine vision care, etc., are matters subject to legislative action or regulatory rule making not appealable under TRICARE.

Contractors will not make a determination that an issue is not appealable except as specified in the *OPM Part Three, Chapter 7* and the 32 CFR 199.10.

Nonavailability Statement (NAS). A statement issued by a commander (or designee) of a Uniformed Services medical treatment facility that needed medical care being requested by a TRICARE beneficiary cannot be provided at the facility concerned because the necessary resources are not available. Requirement for a non-availability statement is currently limited to inpatient treatment, but may, at the direction of the Assistant Secretary of Defense (Health Affairs), be extended to specific types of outpatient care. TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option.

Non-Claim Health Care Data. That data captured by the contractor to complete the required Health Care Service Record information for care rendered to TRICARE beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

Noncurrent Records. Records that are no longer required in the conduct of current business and therefore can be retrieved by an archival repository or destroyed.

Non-DoD TRICARE Beneficiaries. These are TRICARE-eligible beneficiaries sponsored by non-Department of Defense uniformed services (the Commissioned Corps of the Public Health Service, the United States Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration).

Non-Network Care. Any care not provided by "network providers" (see definition of "Network Care"), except care provided to a TRICARE Prime enrollee by a "non-network provider" **upon referral** from the contractor. A "non-network provider" is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries. A "non-network claim" is one submitted for "non-network care."

Non-Prime TRICARE Beneficiaries. These are TRICARE-eligible beneficiaries who are not enrolled in the TRICARE Prime program. These beneficiaries remain eligible for all services specified in 32 CFR 199 and are subject to deductible and cost-share provisions of the TRICARE Standard Program.

Notice of Award. A communication by the Contracting Officer formally notifying the incoming contractor by letter, wire, or telephone of the contract award.

Operations Manual - (6010.49-M). The manual which provides the instructions and requirements for claims processing and health care delivery under TRICARE when these services are delivered under fixed-price, at-risk contracts for benefits and administration.

Otherwise Authorizing Document.

1. Mechanisms, such as registration and certification, by which a State, the District of Columbia, a Commonwealth, territory, or possession of the United States grants authority to provide healthcare independently in a specified discipline; or

2. In specialties not licensed, or where the requirements of the granting authority for registration or certification are highly variable, a validation (provided by national organizations based on professional qualifications) to provide healthcare services independently in a specified discipline; or,

3. In the case where healthcare is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare independently in a specified discipline.

Out-of-Region Beneficiaries. TRICARE-eligible beneficiaries who reside outside of the region for which the Contractor has responsibility, but who receive care within the region.

Out-of-System Care. See "Non-Network Care."

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider who furnishes services or supplies to a TRICARE beneficiary and has agreed, by act of signing and submitting a TRICARE claim form and indicating participation in the appropriate space on the claim form, to accept the TRICARE-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the TRICARE allowance or requiring cost-sharing by the beneficiary or sponsor. All network providers MUST be participating providers.

Peer Review Group (PRG). A group of professional reviewers contracted with by the government to perform external peer review of the care provided under TRICARE. See the definition for "provider network."

Pending Claim, Correspondence, or Appeal. The claim/correspondence/appeal case has been received but has not been processed to final disposition.

Point-of-Service (POS) Option. Option under TRICARE Prime that allows enrollees to self-refer for non-emergent health care services to any TRICARE authorized civilian provider, in or out of the network. When Prime enrollees choose to use the POS option, i.e., to obtain non-emergent health care services from other than their PCMs or without a referral from their PCMs, all requirements applicable to TRICARE Standard apply except the requirement for an NAS. Point-of-Service claims are subject to deductibles and cost-shares (refer to definitions in this chapter) even after the Fiscal Year catastrophic cap has been met (refer to Policy Manual, Chapter 12, Section 10.1).

Preferred Provider Organization (PPO). An organization of providers who, through contractual agreements with the contractor, have agreed to provide services to TRICARE beneficiaries at reduced rates and to file TRICARE claims on behalf of the beneficiaries and accept TRICARE assignment on all TRICARE claims. The preferred provider agreements may call for some other form of reimbursement to providers, but in no case will an eligible beneficiary receiving services from a preferred provider be required to file a TRICARE claim or pay more than the allowable charge cost-share for services received.

Prevailing Charge. The charges submitted by certain non-institutional providers which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of the range establishes the maximum amount TRICARE will authorize for payments of a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge. The calculation methodology and use is determined according to the instructions in the OPM Part Two, Chapter 4.

Primary Care. Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

Primary Care Manager (PCM). *An MTF provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.*

PRIMUS. An Army acronym for Primary Care for the Uniformed Services.

Priority Correspondence. Correspondence received by the contractor from the Office of the Assistant Secretary of Defense (Health Affairs), TMA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

Privacy Act, Title 5, United States Code, Section 552 a. A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

Processed to Completion (or Final Disposition).

1. Claims.

Claims are processed to completion, for workload reporting and payment record coding purposes, when all claims received in the current and prior months have been processed to the point where the following actions have resulted:

a. All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and checks and EOBs have been prepared for mailing to providers and beneficiaries, and

b. Payment, deductible application or denial action has been posted to ADP history.

2. Correspondence.

Correspondence is processed to completion when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.

3. Telephonic Inquiry.

A telephonic inquiry is processed to completion when the final reply is provided by either telephone or letter.

4. Appeals.

Final disposition of an appeal case occurs when the previous decision by the contractor is either reaffirmed, reversed, or partially reversed and the decision is mailed.

Program for Persons with Disabilities (PFPWD). The special program set forth in 32 CFR 199.5, through which family members of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically disabled over and above those medical benefits available under the *TRICARE Standard* Program.

Profiled Amount. The profiled amount is the lower of the prevailing charge or the maximum allowable prevailing charge.

Program Integrity System. A system required of the contractor by the government for detecting overutilization or fraud and abuse.

Provider. A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with the *32 CFR 199*.

Provider Network. An organization of providers with which the contractor has made contractual or other arrangements. These providers must accept assignment of claims and submit claims on behalf of the beneficiary.

Prospective Review. Evaluation of a provider's request for treatment of a patient before the treatment is delivered. This typically involves a provider requesting admission (non-emergent) or requesting selected procedures that require pretreatment certification and authorization for reimbursement.

Quality Assurance Program. A system-wide program established and maintained by the contractor to monitor and evaluate the quality of patient care and clinical performance.

Receipt of Claim, Correspondence or Appeal. Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

Reconsideration. An appeal to a contractor of an initial determination issued by the contractor.

Records. All books, papers, maps, photographs, machine readable materials, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the United State Government under Federal law or in connection with the transaction of public business or appropriate for presentation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the government.

Records Management. The area of general administrative management concerned with achieving economy and efficiency in the creation, use and maintenance, and disposition of records. Included in the fulfilling of archival requirements and ensuring effective documentation.

Reference Material. Such items as the *32 CFR 199*, Operations Manual, Policy Manual, Procedural Code manuals, Diagnostic Code manuals, TMA Instructions, drug books, medical dictionaries and other materials, as appropriate to the needs of the operating unit.

Region. A geographic area determined by the government for civilian contracting of medical care and other services for TRICARE/CHAMPUS-eligible beneficiaries.

Regional Review Authority (RRA) The entity performing PRO functions as outlined in the *ADP Manual, Chapter 10* and OPM Part Three, Chapter 7. The MCS contractor performs the duties of the RRA.

Relative Value Unit (RVU). Valuation or rating of physician services on the basis of relative physician resource inputs (work and other practice costs) to provide medical services. Specifically refers to relative physician work values developed by the Harvard University RBS study. (Only for Medicare RVUs given to contractors as part of the CMAC file for use in CMAC pricing.)

Residual Claim. A claim for health care services rendered in an at-risk region to a patient who is not a resident of that region.

Resource Sharing Agreement. This is an agreement between the Contractor and individual military treatment facility commanders to provide or share equipment, supplies, facilities, physicians, nurses, or other trained staff who are under contract with, or employed by, the Contractor for work in MTFs for the purpose of enhancing the capabilities of MTFs to provide needed patient care to beneficiaries.

Resubmissions. A group of Health Care Service Records (HCSR) submitted to TMA to correct those Health Care Service Record claims and adjustments which generated edit errors when originally processed by TMA. These groups of records will be identified by the batch number and resubmission in the HCSR Header Record.

Retention Period. The time period for particular records (normally a series) to be kept.

Retrospective Review. Evaluation of care already delivered to determine appropriateness of care and conformance to pre-established criteria for utilization. The purpose for this type of review may be to validate utilization decisions made during the review process and/or to validate payment made for care provided (by examining the actual record of treatment).

Returned Claim. Any TRICARE claim, with attached documentation, containing less than sufficient information for processing to completion; a copy, or the original of, which must be sent back for completion of required data, rather than retaining and developing by letter request, alone. A "Returned Claim" will normally be retained under contractor control in the "pending" claim inventory. A Coordination of Benefits claim returned to the claimant when OHI is known to exist, or other claims authorized for return "not under control", are not included as a "returned claim."

Risk Sharing. A contractual agreement between the government and the Contractor for sharing the financial burden or risk associated with the delivery of medical care services.

Routine Correspondence. Any correspondence which is not designated as Priority Correspondence.

Service Point of Contact (SPOC). *The uniformed services office or individual responsible for coordinating civilian health care for active duty service members (ADSMs) who receive care under the Supplemental Health Care Program and the TRICARE Prime Remote Program. The SPOC reviews requests for specialty and inpatient care to determine impact on the ADSM's fitness for duty; determines whether the ADSM shall receive care related to fitness for duty at a military medical treatment facility (MTF) or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness-for duty and/or retention on active duty. SPOCs for the Army, Navy/Marines, and Air Force are assigned to the Military Medical Support Office (MMSO). [See "Military Medical Support Office (MMSO)."] See OPM Part Three, Chapter 8, Addendum A, for location of the Coast Guard SPOCs.*

Special Checks. Checks issued outside the normal processing workflow for the purpose of expediting payment of a claim for benefits.

Special Inquiries. Freedom of Information Act requests; Privacy Act requests; information requests by the news media; surveys, audits, and requests by Government agencies (including Department of Defense agencies and entities other than TMA) and Congressional Committees.

Specialized Treatment Service Facilities (STSFs). Health care facilities designated by the Assistant Secretary of Defense (Health Affairs) to have catchment areas for specified services exceeding the standard 40-mile radius. These services are high-cost procedures for which the STSF has special capabilities. One example of an STSF is Wilford Hall Medical Center, San Antonio, Texas, which is designated as an STSF for bone marrow transplants. Refer to OPM Part Two, Chapter 24, for information on STSFs.

Specialty Care. Specialized medical services provided by a physician specialist.

Split Enrollment. Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support (MCS) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.

Start Work Date. The date the incoming Contractor officially begins delivery of health care services, processing claims, and delivery of other services in a production environment, as specified in the contract.

Subcontracts. The contractual assignment of elements of requirements to another organization or person for purposes of TRICARE. Unless otherwise specified in the contract, the term also includes purchase orders, with changes and/or modifications thereto.

Subcontractors. Includes, but is not limited to, enrolled program health benefits business entities at whatever level of the contract organization they exist and institutional and non-institutional providers of health care under agreement or contract to the prime contractor. It does not include institutional or non-institutional providers of health care under agreement or contract to subcontracted enrolled program health benefits business entities.

Institutional and non-institutional providers are those hospitals, physicians, laboratories, pharmacies or other entities as defined by 32 CFR 199.6 that provide care or services directly related to delivery of health or mental health care to TRICARE-eligible beneficiaries.

In determining whether a business entity is a network first tier subcontractor, consideration is given as to whether or not the entity providing the designated services acts as a broker of care; i.e., the entity itself obtains the medical coverage needed by in turn contracting with institutional and non-institutional providers. As a subcontractor, the entity itself usually, but not always, has no inherent provider resources, or if it does, it must augment its resources by contracting to meet the government's requirements. Implicit in the determination is size of the offered network; i.e., does this entity provide a large number of contracted providers for a large geographical area such as a whole state?

This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the FAR.

Supplemental Care. Care ordered, directed and paid for by the MTF.

Supplemental Funds. Funds used to pay for supplemental care.

Supplemental Insurance. *Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.*

TPR (TRICARE Prime Remote) Program. *A health care program for active duty members of the Armed Forces who are assigned to permanent duty stations in areas that are not near sources of military medical care. See OPM Part three, Chapter 8.*

TPR Work Unit. *An armed Forces work unit whose members are eligible to enroll in the TRICARE Prime Remote (TPR) Program as designated by the Armed Forces.*

Third Party Liability (TPL) Claims. Third party liability (TPL) claims are those for services to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. Contractors and the government pursue repayment of care provided the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (42 U.S.C. paragraphs 2651-2653).

Third Party Liability (TPL) Recovery. The recovery of expenses incurred for medical care for personal injuries or illnesses on behalf of a TRICARE beneficiary from a third party source. Such recoveries can be made from a liable third party or his or her liability insurance (third party liability) or from a medical payments plan which covers the beneficiary for personal illness or injury. The contractor and the government will pursue recovery under the provisions of the Federal Medical Care Recovery Act (42 U.S.C. Paragraphs 2651-2653).

Toll-Free Telephones. All telephone calls are considered toll-free for the purposes of measuring the standards contained in OPM Part One, Chapter 1, Section III.E.3., except for those telephone calls to a TRICARE Service Center.

Transfer Claims. A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification must be sent to the claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

Transition. The process of changing Contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

Transitional Assistance Management Program. The Transitional Assistance Management Program (TAMP) was established to provide short-term transitional TRICARE and MTF benefits to certain former TRICARE beneficiaries.

Transitional Patients or Cases. Patients for whom active care is in progress on the date of a Contractor's start work date. If the care being provided is for covered services, the Contractor is financially responsible for the portion of care delivered on or after the Contractor's start work date.

Treatment Encounter. The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

Triage. A method of assessing the urgency of need for medical care using the patient's complaints and medical algorithms or other appropriate methods for analysis and then arranging for care. Medically qualified contractor personnel on 24-hour telephone coverage will perform the function.

TRICARE. The Department of Defense's managed health care program for active duty service members, service families, retirees and their families, survivors, and other

TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions below).

TRICARE Extra Plan. A "preferred provider program." A TRICARE beneficiary not enrolled in TRICARE Prime may receive medical care from TRICARE network providers usually at a reduced cost under the TRICARE Extra Plan.

TRICARE/CHAMPUS Policy Manual (6010.47-M). A TMA manual which provides the description of program benefits, adjudication guidance, policy interpretations, and decisions implementing the TRICARE Program.

TRICARE Prime Plan. A voluntary enrollment program offered by a government-selected Contractor that is at-risk for the benefit dollars. "Prime" must provide enhanced TRICARE benefits to all enrolled beneficiaries who live in areas where it exists. The TRICARE Prime Plan will usually be offered in military treatment facility catchment areas.

TRICARE Prime Remote Program (Geographically Separated Unit Program). The program designed to provide health care services to active duty members of the armed forces (Army, Air Force, Navy, and Marines) who meet the eligibility criteria below:

The active duty service member (ADSM) must have a permanent duty assignment that is greater than 50 miles (based on ZIP codes) from a military medical treatment facility (MTF) or military clinic designated as adequate to provide the needed primary care services to the ADSM; and

Pursuant to the assignment of such duty, the ADSM resides at a location that is greater than 50 miles (based on ZIP codes) from an MTF or military clinic designated as adequate to provide the needed primary care services to the ADSM.

The armed forces determine eligibility for the TRICARE Prime Remote (TPR) program; the contractor enrolls designated ADSMs in TPR. At the discretion of the Government, exceptions may be made. Where the unit is located in one region (or contract area) and the ADSM lives in an area served by a different contractor, the ADSM may be enrolled with the contractor for the region serving the unit's location rather than the ADSM's residence. Where geographical barriers or other unique situations are determined to exist (e.g., the drive time to the closest MTF exceeds one hour), the unit commander may submit a request for a waiver of the eligibility requirements to the regional Lead Agent. The Lead Agent will review the request and forward a recommendation along with the unit commander's request to the Chief Operating Officer, TRICARE Management Activity (TMA), Skyline Five, Suite 810, 5111 Leasburg Pike, Falls Church, VA 22041-3206, for a determination.

TRICARE Regulation. *32 CFR 199*. This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the U.S. Public Health Service (USPHS) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). It includes the guidelines and policies for the administration of the TRICARE Program.

TRICARE Representative. A highly qualified service representative serving within a defined part of a contractor's region, providing information and assistance to providers,

whether network or non-network, to Health Benefit Advisors (HBAs) in the service area and to congressional offices.

TRICARE Standard Plan. The current TRICARE Program specified by law (Title 10, United States Code); the *32 CFR 199*, the TRICARE/CHAMPUS Policy Manual (6010.47-M) and the Operations Manual (6010.49-M). TRICARE Standard includes the Basic Program and the Program for Persons with Disabilities (PFPWD).

Unbundled (or Fragmented) Billing. A form of procedure code manipulation which involves a provider separately billing the component parts of a procedure instead of billing only the single procedure code which represents the entire comprehensive procedure.

Unclean Claim. A claim received by the contractor that lacks any required documentation or authorization.

Uniformed Services Clinic (USC). *A Military Health System clinic that delivers primary care to active duty service members (ADSMs).*

Uniformed Services Family Health Plan (USFHP). A government-contracted health plan that offers enrollment in TRICARE Prime to individuals who reside in the geographic service area of a USFHP designated provider who are eligible to receive care in military medical treatment facilities (except active duty service members). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE benefits. Designated providers under the USFHP were previously known as "Uniformed Services Treatment Facilities" (USTFs) and are former Public Health Service Hospitals. The service areas of the USFHP designated providers are listed at "http://www.usfhp.org" on the world wide web and under "USTF" in the Catchment Area Directory.

United States. "United States" means the fifty (50) states and the District of Columbia.

United States Public Health Service (USPHS). An agency within the U.S. Department of Health and Human Services which has a Commissioned Corps which are classified as members of the "Uniformed Services."

Unprocessable Health Care Service Records. Health care service records transmitted by the contractor to TMA and received in such condition that the basic record identifier information is not readable on the TRICARE data system, i.e., header incorrect, electronic records garbled, etc.

Utilization Criteria. Specific conditions that must be met in order to provide appropriate treatment. DoD-approved criteria to use for screening medical/surgical care and for mental health care as outlined in OPM Part Three, Chapter 3.

Utilization Management. A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness and medical necessity of care either prior to, during, or after provision of care. Utilization management also includes the systematic evaluation of individual and group utilization patterns to determine the effectiveness of the employed utilization management techniques and to develop modifications to the utilization management system designed to address aberrances identified through the evaluation.

Utilization Review. A process of case-by-case examination for consistency of the provider's request for specific treatment(s) (e.g., level of care, procedures, etc.) with preestablished criteria. Specific types of review include (but are not limited to) prospective review, concurrent review, and retrospective review. For the purposes of this contract, utilization review will be mandatory for enumerated conditions and treatments in order to generate certification and authorization for care provided.

Vendor Pharmacy. A participating provider pharmacy not under contract with the contractor as a member pharmacy.

Visit.

1. Civilian Care Setting.

a. Those medical care procedures characterized by the professional examining and/or evaluating a patient and delivering or prescribing a care regimen. Professional visit procedures include CPT procedure codes 90000 - 90499, 90571 - 97799, 99175 - 99195, 99155 - 99156, each range inclusive except 90596, 90597, and 90599; and including emergency room visit procedure codes 90500 - 90570 and 90599.

2. Military Medical and Dental Treatment Facilities.

a. The definition of a visit as used in the Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual, DoD 6010.13-M (MEPRS Manual) applies. "Each time an eligible beneficiary presents himself to a separate organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation, counseling, medical advice; or is treated or observed in his quarters; and a signed and dated entry is made in the patient's health record or other record of medical treatment, then a visit is considered to have been completed and is countable; however, with the exception that consecutive clinic visits to specialty clinics, i.e., physical therapy and occupational therapy, will not require a signed and dated entry at each visit, unless there is a change in the prescribed treatment, or significant physical finding is evident. In all instances, however, an acceptable record audit trail will be maintained. For example, a clinic log or treatment card may be maintained as a source document to support an audit trail. Classification of a service as a visit will not be dependent on the professional level of the person providing the service (includes physicians, nurses, physician's assistants, medical specialists, and medical technicians)." The MEPRS Manual definition contains added instructions related to the MTF counting of a "Visit." See Addendum A of this chapter for detail.

Wilford Hall Bone Marrow Project (Demonstration). A 5-year TMA/Air Force demonstration project authorized under the Demonstration authority (see definition of "Demonstration") to determine the feasibility of a centralized patient management system for allogeneic bone marrow transplants at Wilford Hall Medical Center. All allogeneic bone marrow transplant surgeries are under case management by the Wilford Hall medical staff.

Workday. A day on which full-time work is performed.